Psychology & Sexuality
This is an Accepted Author version of an article published by Taylor & Francis in Psychology & Sexuality in 2021
https://doi.org/10.1080/19419899.2021.1897033

"It's how the world around you treats you for being trans": Mental health and wellbeing of transgender people in Aotearoa New Zealand

Kyle K. H. Tan[a], Johanna M. Schmidt[b], Sonja J. Ellis[c], Jaimie F. Veale[a] & Jack L.Byrne[a,d]
[a]School of Psychology, University of Waikato, Hamilton, New Zealand
[b]School of Social Sciences, University of Waikato, Hamilton, New Zealand
[c]School of Education, University of Waikato, Hamilton, New Zealand
[d]TransAction, Auckland, New Zealand

To cite this article: Kyle K. H. Tan, Johanna M. Schmidt, Sonja J. Ellis, Jaimie F. Veale & Jack L. Byrne (2021) 'It's how the world around you treats you for being trans': mental health and wellbeing of transgender people in Aotearoa New Zealand, *Psychology & Sexuality.* Advanced online publication. DOI: 10.1080/19419899.2021.1897033

ABSTRACT:
Globally, transgender people have been described as a highly marginalised population due to cisgenderism that delegitimises their gender identities and expressions. Despite robust evidence from many countries noting the association of discrimination and stigma for being transgender with heightened mental health risks, qualitative research that examines the nuances of mental health indicators using health equity frameworks has been scant both in Aotearoa/New Zealand and overseas. Using an inductive thematic approach, this paper analysed 222 open-text responses in the mental health section of the 2018 Counting Ourselves: Aotearoa New Zealand, Trans and Non-binary Health Survey. Our findings showed four overarching themes: gender-affirming healthcare, mental healthcare services and accessibility, gender minority stress, and self-affirmation and social support. Participants' narratives described pervasive gender minority stress experiences in gender-affirming and mental healthcare services, including unmet healthcare needs, lack of competency in healthcare delivery, and pathologisation of their genders. In social settings, our participants commonly reported discrimination and violence, although they also reported that self-affirmation strategies and social support offset the impacts of gender minority stress on their mental health. The current findings indicate the importance of exploring mental health outcomes for transgender people in relation to cisgenderism and resultant gender minority stress.

KEYWORDS: Transgender; cisgenderism; minority stress; gender minority stress; mental health; healthcare services

Introduction

The term *transgender* commonly refers to people whose gender differs from their sex assigned at birth. It is used as an umbrella term to encompass, trans men (people assigned female at birth who identify as/are men), trans women (people assigned male at birth who identify as/are women), and people with non-binary genders (those who identify as/are other genders, across a spectrum of gender diversity; American Psychological Association, 2015). In Aotearoa/New Zealand, there are many ways of understanding gender diversity, including those specific to Pākehā (New Zealand European), Māori, Pacific, and Asian cultures (Tan et al., 2019). Gender diverse identities within Māori and Pacific cultures may carry historical, political, and social connotations that are not directly translatable to western concepts, and these are reflected in a range of identifications such as Māori takātapui, whakawahine, and tangata ira tāne, and Pacific identities including Sāmoan fa'afafine and Cook Islands Māori akava'ine (Tan et al., 2019). In an attempt to minimise the limitations associated with the usage of the umbrella term 'transgender' to cover this broad range of diversity, we will be giving specific attention to race/ethnicity, gender, and age group differences in our analyses.

Cisgenderism and gender minority stress

Cisgenderism refers to discriminatory attitudes, policies, and practices against transgender people at systemic level, which may be related to cisnormativity that identifies cisgender people as the dominant, normal, and superior group (Ansara, 2010; Tan et al., 2020a). The privileging of cisgender identities through cisgenderism and cisnormativity is an example of the injustice of exclusionary social norms (Ansara, 2010), as it exposes people who do not conform to the cisnormative expectations of being a cisgender man or a cisgender woman to gender minority stressors (e.g. prejudice, discrimination, and violence; Tan et al., 2020a). Gender Minority Stress Theory postulates that transgender people face a continuum of stressors, ranging from distal to proximal (Tan et al., 2020a; Testa et al., 2015). Distal stressors are external events, such as discrimination and victimisation that occur at interpersonal (e.g. peer rejection and cyberbullying) and structural (e.g. barriers in obtaining legal gender recognition) levels (Testa et al., 2015). Proximal stressors refer to subjective experiences such as the internalisation of cisgenderism, the development of expectations related to distal stressors, and the concealment of one's gender identity (Tan et al., 2020a; Testa et al., 2015).

Testa et al. (2015) found evidence that proximal stressors partially mediate the effect of distal stressors on mental health. This suggests that mental health concerns (e.g. psychological distress and suicidality) among transgender people originate from distal stressors and may be influenced by individuals' proximal appraisal systems or evaluation of minority stress experiences (Tan et al., 2020a). The negative consequences of minority stress, however, can be mitigated when transgender people have adequate access to protective factors. Some of the most crucial domains of social support with known protective influences on transgender people's mental health are family and peer support (Fuller & Riggs, 2018; Olson et al., 2016; Singh et al., 2014; Veale et al., 2017) and a sense of connection to a transgender community (Brennan et al., 2017; Singh et al., 2014; Testa et al., 2015). Individual-level protective factors

such as identity pride are also important aspects of resilience among transgender people to buffer against gender minority stress (Testa et al., 2015) and can be fostered, as necessary, with support from mental health professionals and social support networks (Singh et al., 2014).

Mental healthcare access

Access to mental healthcare is undoubtedly of major importance for transgender people, given the high prevalence of mental health difficulties due to gender minority stress (Ellis et al., 2015; James et al., 2016; Tan et al., 2020b). Despite transgender people's higher mental health needs, transgender people face difficulties in accessing equitable mental healthcare services due to cisgenderism. The 2012 United Kingdom, Trans Mental Health Study reported one-third (34%) of participants were dissatisfied with their mental healthcare experiences and approximately half (51%) expressed concerns about discussing their gender with a healthcare provider (Ellis et al., 2015). Other studies also showed that transgender people were likely to delay accessing mental healthcare services and terminate mental healthcare services prematurely due to unhelpful healthcare providers who, for example, misgendered their clients or appeared to lack trans-specific knowledge (Alpert et al., 2017; Halliday & Caltabiano, 2020; Pitts et al., 2009).

Gender-affirming healthcare

Provision of mental healthcare services and gender-affirming care is not always mutually exclusive in Aotearoa/New Zealand, as an assessment by a mental health professional is usually required for access to gender-affirming surgeries. Transgender people might also consult mental health professionals for assistance with the informed consent process while accessing other gender-affirming care such as hormone prescriptions (Oliphant et al., 2018) although this is not always required. At the time of writing, hormone therapy can be accessed through primary healthcare, sexual health services, and hormone specialists, though District Health Boards (DHBs) outside the larger cities reported some difficulties in providing these services (PATHA, 2019; Veale et al., 2019). Gender-affirming surgeries such as chest reconstruction, and to a lesser extent breast augmentation, are provided by specialists in some local District Health Board (DHB) areas (Ministry of Health, 2020). Referrals to a publicly funded national gender-affirming (genital) surgery service require transgender people to have a readiness assessment from a health professional (e.g. mental health professional, endocrinologist, or sexual health physician) who has gender-affirming healthcare expertise (Ministry of Health, 2020). It can be difficult for transgender people to access referrals due to the absence of clear gender-affirming pathways in each DHB and limited knowledge about, trans health across the wider health workforce. Limited capacity for all gender-affirming healthcare results in a high level of unmet need (Veale et al., 2019) and at least a 10-year waiting time for genital reconstruction surgeries.

There is a rising demand for gender-affirming medical interventions with substantial growth in the number of transgender people seeking such services across different countries (Delahunt et al., 2016; Telfer et al., 2018). Studies have demonstrated the positive associations between such gender- affirming interventions (e.g. hormones and surgeries) and the mental health of transgender people, as these interventions help align transgender people's physical characteristics with their affirmed gender and to alleviate bodily gender dysphoria for many transgender people (Brennan et al., 2017; Tomita et al., 2019). For transgender people who were actively seeking gender-affirming surgery but could not access it, a study with a transgender sample in China found that they were at greater odds of developing suicidal thoughts (Chen et al., 2019). In spite of the negative mental health effects associated with the inability to fully affirm their gender, transgender people often have to wait for a long duration before being able to access gender-affirming care (Ellis et al., 2015).

Objectives

International research (e.g. James et al., 2016; Pitts et al., 2009) has consistently demonstrated stark mental health inequities affecting transgender people compared to their cisgender counterparts. Research that describes the nuances of mental health indicators affecting transgender people in Aotearoa/New Zealand has been limited, however. While there are numerous qualitative studies that have researched transgender people's experiences of healthcare access (e.g. Alpert et al., 2017; Halliday & Caltabiano, 2020), and gender minority stress and protective factors (e.g. Howell & Allen, 2020; Singh et al., 2014), these studies have not specifically investigated the relationships of these determinants to mental health outcomes. This qualitative paper is the first, to our knowledge, to exclusively analyse open-text survey responses from a large nationwide sample of transgender people, with the objective of exploring the mental health needs of transgender people. Building on Gender Minority Stress Theory (Tan et al., 2020a; Testa et al., 2015), we analyse participants' responses by accounting for the influences of structural and environmental contexts alongside the full range of determinants from biological, psychological, to social, that play crucial roles in promoting mental health equity among transgender people (Fredriksen-Goldsen et al., 2014).

Method

The data presented here was obtained as part of the 2018 Counting Ourselves: Aotearoa New Zealand, Trans and Non-Binary Health Survey, which recruited 1,178 transgender people aged 14 or older who lived in Aotearoa/New Zealand. This comprehensive study collected data on transgender people's physical and mental health, experiences in general and gender-affirming healthcare services, gender minority stress experiences, and levels of support from friends, family, and the wider community. The survey received ethical approval from the New Zealand Health and Disability Ethics Committee (18/NTB/66/AM01) and was open for participation between June and September 2018. In order to maximise the diversity and representativeness of our sample of transgender people, our recruitment strategy involved reaching out to potential participants via social media (e.g. Facebook), community newsletters and notice boards, and word of mouth

by collaborating with community advisory group members, academic researchers, and health professionals working with transgender people.

There were 1,380 initial responses, with 1,178 of these meeting the inclusion criteria. These excluded responses that were duplicates, participants not from Aotearoa/New Zealand, and participants who did not complete the demographic section to indicate that they were transgender (see Veale et al. (2019), for more details). As this was a lengthy survey, attrition led to some partial completions; however, more than three quarters of participants (n = 905) completed the mental health section of the survey.

A general open-text question was placed at the end of each topic section of the survey, with the aim to identify additional issues that were not covered by the closed questions. In this paper, we analysed the open-ended question in the mental health section 'Is there anything further about your mental health that you would like to share with us?' Responses such as 'no' and 'no, all good' were treated as non-responses and excluded from analysis, leaving 222 responses to this specific question that were included in this analysis. Each response was classified by the participant's gender (i.e. trans man, trans woman or non-binary), age group (Youth: 14–24; Adult: 25–54; Older adults: 55 and above), and ethnicity.

Analysis

A thematic analysis was employed to analyse qualitative comments from the open-text question and identify patterned codes and themes (Clarke et al., 2015). Specifically, we chose the inductive approach of thematic analysis that positioned participants as the chief informants of their own experiences. Critical realism recognises the existence of reality as socially determined and proposes that there is a need to provide contextual analyses by bridging the disjuncture between human beings and social context (Cruickshank, 2012; Danermark et al., 2002). As critical realism treats the social world as theory-laden (Cruickshank, 2012; Danermark et al., 2002), this study drew on Gender Minority Stress Theory (Tan et al., 2020a; Testa et al., 2015) to explore how our participants made sense of their mental health in relation to wider social environments and associated norms (e.g. cisgenderism). The coding process began with the first and second authors (KT and JS) familiarising themselves with the data and then systematically reading all of the responses to generate initial codes. Any discrepancies in coding decisions were reviewed by the third author (SE) and the three authors worked together to compare and refine codes before grouping the responses into a set of mutual categories. Suggestions were also made to amalgamate codes into themes during this process. All coding themes were jointly discussed and a consensus was reached among all authors. An individual response could contribute to more than one code or theme if the comments touched on several issues.

Given that only 19% of those who undertook the survey, and 25% of those who completed the mental health section, elected to provide a response to this open-ended question, we were interested to see if there were any demographic differences among this group compared to the overall sample. IBM SPSS Statistics version 25 was used to conduct this quantitative analysis. Differences in the proportion of participants who left a qualitative comment by demographics (gender, age, and ethnicity/race) were determined with chi-square goodness-of-fit ($\chi 2$) tests. Standardised adjusted residuals were used to identify statistically significant differences between the number of cases observed and the number expected in a cell. Residual values that exceed ± 1.96 indicate the proportion of participants who left a comment versus those who did not to differ significantly for a demographic group. These results showed that only youth participants were less likely, and older adults more likely, to respond to this question; the statistical findings are outlined in online supplementary file (Table S1).

Results and Discussion

Our qualitative analysis resulted in four overarching themes to summarise the contents across participants. While each theme is distinct, they needed to be considered alongside each other to paint a coherent picture of the determinants of mental health for transgender people. Figure 1 presents the thematic map of four determinants that our participants described as essential to their mental health.

Gender-affirming care

Unmet need for gender-affirming healthcare is a prevalent issue for transgender people in Aotearoa/ New Zealand. In the Counting Ourselves survey, unmet need was defined as those who wanted but could not access specific medical interventions. For instance, there was a high percentage of Counting Ourselves participants who had an unmet need for hormone treatment (19%), breast augmentation surgery[1] (35%), and chest reconstruction surgery[2] (48%) (Veale et al., 2019). Many participants reported that not being able to access gender-affirming medical interventions impacted negatively on their mental health, for example:

> *Any depression I experience is due to the fact that my exterior physical image does not match the psychological image I wish to be that could be corrected by surgeries that I can neither afford or could see happening through the NZ health system anytime within my lifetime.* (NZ European/Pākehā, Trans woman, Adult)

Consistent with previous studies (Brennan et al., 2017; Ellis et al., 2015; Tomita et al., 2019), our participants who had undertaken medical procedures to affirm their gender had better mental health and wellbeing because of this, for example: 'I used to have serious clinical depression, from my early teens. When I started taking cross-hormones all that disappeared within a couple of weeks. Turns out in my case it's largely a matter of hormonal balance' (Māori, Trans man, Adult).

[1]Among trans women and non-binary participants assigned male at birth

[2]Among trans men and non-binary participants assigned female at birth

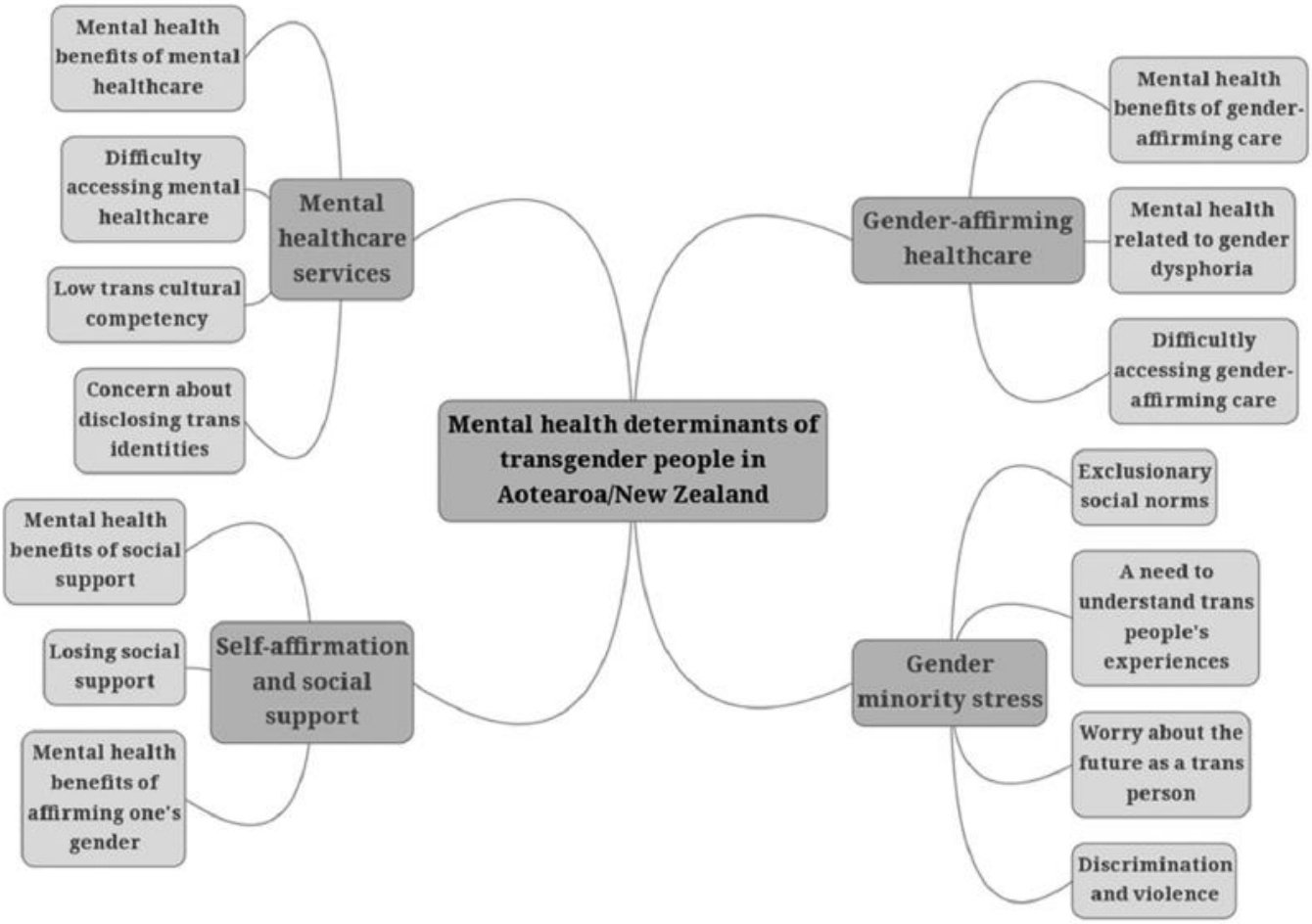

Figure 1. Thematic map of mental health determinants of transgender people in Aotearoa/New Zealand.

In 2018, a multidisciplinary group of health professionals developed a guideline document for the provision of gender-affirming care that is culturally relevant to Aotearoa/New Zealand context (Oliphant et al., 2018). The document recognised the high unmet needs for gender-affirming medical interventions and the current practising of pathologisation models by some health professionals that have presented challenges for transgender people to access medically necessary healthcare (Oliphant et al., 2018). An example of this is the reliance on the Diagnostic Statistical Manual (DSM; American Psychiatric Association, 2013) to assess eligibility for gender-affirming care. One participant demonstrated their dissatisfaction with the pathologisation of transgender identity through the DSM model.

I don't put much value in the DSM and think it is absurd. It's been historically used to police gender normative behaviour and I am very uncomfortable with the way we are now trying to get the psychiatric discipline onside in our quest for gender rights. Master's house with the master's tools and all that. I'm not on board. (NZ European/Pākehā, Non-binary, Adult)

The perception that gender diversity is an indicator of mental disorder has been institutionalised since the listing of 'transvestism' in DSM-I (American Psychiatric Association, 1952) and 'transsexualism' in the International Classification of Disease (ICD-9; World Health Organization, 1975). The continued listing of transgender people's experiences as a diagnostic category, including 'gender dysphoria' in DSM-5 has been critiqued for reinforcing the pathologisation of transgender identities and the normalisation of cisgender identities, as well as implying that medical intervention is a mandatory trajectory for transgender people to affirm their genders (Castro-Peraza et al., 2019; Tan et al., 2019). Transgender scholars and advocates have celebrated the World Health Organization's recent depathologisation of transgender identities (Castro-Peraza et al., 2019), signalling that they will move the diagnosis for transgender people from the Mental and Behavioural Disorders chapter to the new chapter of Conditions Related to Sexual Health in the 11th edition of the ICD (World Health Organization, n.d.). This depathologing movement implies that being transgender should no longer be considered a mental illness. The findings discussed here also reflect that being gender diverse is not the cause of the distress that many transgender people experience– rather, this distress is related to societal reactions to gender diversity and transgender people's inability to access services many need to affirm their genders.

Mental healthcare service and accessibility

Published findings using the same study as this paper showed transgender people in Aotearoa/New Zealand were experiencing disproportionate mental health burdens with approximately nine times higher psychological distress for transgender people (72%) compared to the general population (8%; Tan et al., 2020b). The Counting Ourselves report also revealed a high prevalence of transgender people engaging in

suicidal thoughts (56%) and suicide attempts (12%) in the past year, findings which have been found to be associated with gender minority stress experiences (Veale et al., 2019). Given the high prevalence of mental health concerns that transgender people face, it is no surprise that they are more likely to seek mental healthcare services for support related to the consequences of gender minority stress or concerns regarding their mental health.

The benefits of mental healthcare services (e.g. counselling or medication) in providing support in the face of discrimination or rejection, relief from distress, coping skills to manage emotional vulnerabilities, or gender-affirming strategies were mentioned by our participants. One of the hardest periods of my life was when I started transitioning and lost most of friends and the dyke community I lived in at that time. It was very important for me to have access to a psychotherapist to deal with that stress, and the discrimination and exclusion I experienced - either intentionally or because the community at that time did not know how to respond. I was lucky I could afford to pay to see a psychotherapist, especially as there was very little peer support available for, trans men. (NZ European/Pākehā, Trans man, Older adult)

Our findings supported previous studies that have documented high unmet needs for mental healthcare services among transgender people (Ellis et al., 2015; James et al., 2016). The lack of allocated funding to expand the provision of mental healthcare services for minority populations in Aotearoa/New Zealand has led to a long waiting time for transgender people to access much-needed healthcare services (Clunie, 2018; Delahunt et al., 2016). Participants with mental health conditions reported that their conditions were exacerbated by these delays. I don't think my mental health is bad enough that I need to urgently see anyone, but I definitely think I could use some help - if only seeing mental health professionals wasn't so expensive and I didn't have to wait for months and months just to get an appointment. I don't want to die or self-harm, but I don't know how else to explain my constant low mood, lack of motivation, awful sleep schedule, constant tiredness, negative self-talk, sensitivity - among many other symptoms - other than as some kinds of depression? Talking about it and figuring it out with somebody would be nice, but here I am, anonymously typing into a box because I can't get help elsewhere. (NZ European/Pākehā, Non-binary, Youth)

In addition to the high cost of private services and the low availability of publicly provided mental healthcare provision in Aotearoa/New Zealand, even in areas where services were available, many participants reported that having to navigate through a system that largely did not recognise or accept their genders deterred them from visiting mental healthcare professionals. For example, one participant did not think that mental healthcare services would be helpful as 'Most treatments offered comprise of 4 or 5 appointments with counsellors who know nothing about, trans issues. Waste of time and resources' (NZ European/Pākehā, Non-binary, Adult). While the inclusion of such knowledge in the training of medical professions has been deemed essential in promoting inclusivity towards transgender healthcare, a recent study surveying academic staff at Aotearoa/New Zealand medical schools found that little to no content relating to gender diversity was introduced in the preclinical curriculum for medical health professionals such as psychiatrists (Taylor et al., 2018). International studies have found that when mental healthcare service providers possessed sufficient knowledge about transgender issues, they were more likely to respect transgender people by using their preferred name and pronouns, and to have a solid understanding of the gender minority stress that their clients encounter (Ellis et al., 2015; Halliday & Caltabiano, 2020).

Cisgenderist prejudices were also evident in mental healthcare services. As one participant said:

I've often had my mental health conflated with my "trans" status. I've had countless times where assumptions have been made that my mental health is poor due to being apparently "part way" through transitioning or implying that because I haven't had chest surgery for example, that's why I'm in a bad space. (Māori, Non-binary, Adult)

The lack of transgender-competency on the part of mental healthcare professionals, sometimes coupled with judgemental attitudes, can lead transgender people to question the ability of the provider to effectively render care. One participant shared an experience that could be interpreted as a gender identity conversion effort (GICE; Turban et al., 2020), 'I have had a psychiatrist tell me she could "fix" my gender and sexuality as it was caused by trauma. She said this in front of my queer, trans partner' (NZ European/Pākehā, Non-binary, Youth). It is notable that in the Counting Ourselves quantitative data, about one-sixth (17%) of participants reported attempts at gender identity conversion in their lifetimes (Veale et al., 2019). A recent United States survey found that transgender people who were exposed to GICE in their lifetime had higher prevalences of psychological distress and suicidality (Turban et al., 2020). Practices that impede transgender people from affirming their gender are an example of cisnormative indoctrination and have been deemed as unethical and harmful by the New Zealand Psychologists Board (2019). Previous transgender-affirmative research urges mental healthcare providers for transgender people to go beyond clinical competency (i.e. having knowledge of clinical issues related to gender-affirming care) and to include cultural competency (i.e. acknowledge the social context of health inequities affecting transgender people and being inclusive of gender diversity in the content and processes of healthcare delivery (Alpert et al., 2017; American Psychological Association, 2015; Ellis et al., 2015).

Gender minority stress

In their comments, survey participants talked about how their mental health was negatively affected by cisgenderism and gender minority stress. Cisgenderism describes marginalisation and prejudice against transgender people, which often results in pathologising people who do not conform to the conventional cisgender norms (Tan et al., 2020a). The marginalisation of transgender identities in society

may lead to the social isolation of transgender people, an effect that has that much negative influences on mental health, as one participant shared:

While I don't agree with these specific assumptions and diagnoses [gender identity disorder], I do agree that gender variance has influenced my mental health and will continue to. Not because it is an issue for me so much as dealing and navigating in a world that often does it's best to make me alienated, alone, less than. (Māori, Non-binary, Adult)

Another participant criticised the notion that transgender identity is pathological, 'Being, trans isn't something that in itself causes mental distress or harm. It's how the world around you treats you for being, trans that does the harm' (NZ European/Pākehā, Trans man, Adult). The pathologising perspective that transgender identity is a cause of distress has been widely taken for granted without much consideration of the consequences of the specific form of stress that transgender people face due to cisgenderism – gender minority stress (Schulz, 2018; Tan et al., 2019). Many participants conveyed how cisgenderism manifested in their daily lives, including one participant who noted not being acknowledged appropriately for his affirmed gender: 'All the time struggling daily with being misgendered – not seen and read correctly' (NZ European/Pākehā, Trans man, Adult). Other examples of cisgenderism that participants brought up ranged from experiences of violence (e.g. sexual abuse and workplace bullying) and lack of understanding from the society about transgender issues, to the need to advocate for basic human rights to lead a life without being stigmatised. Cisgenderism has specific impacts on those with non-binary identities, which one participant described as being 'non-binary in a binary world' (Māori, Non-binary, Adult), and the need to resist pressure to identify as one of two normative gender categories.

Self-affirmation and social support

Emerging evidence suggests that affirmative family environments can mitigate the high prevalence of mental health concerns among transgender people (Fuller & Riggs, 2018; Veale et al., 2017). One United States study found that socially transitioned transgender youth who were supported by family members in affirming their gender were no more likely than their cisgender counterparts to exhibit depression and anxiety symptoms (Olson et al., 2016). Our participants' responses corroborated these findings, for example, 'Being accepted and affirmed by my family and whānau (extended family) in my preferred gender improved my mental health' (Māori, Trans man, Adult). Conversely, transgender people who were estranged from family members may feel that challenging cisgenderism without support makes them vulnerable, as one participant (Middle Eastern, Trans man, Youth) noted 'There is little to no understanding in society, and often people like myself are told it's our fault that we're miserable. To be "more positive". It is hard, when I don't have family connections'.

In a society where transgender people may often feel socially ostracised, the presence of trans-affirming friends, family, and community members can be crucial in ensuring that transgender people are equipped with support systems to enable them to cope with the effects of gender minority stress (Singh et al., 2014; Testa et al., 2015). Studies found peer support may provide additional mental health benefits on top of support from the family of origin for transgender people, suggesting that they may benefit from extending their networks to form 'families of choice' and peer support groups that comprise members who are supportive of their gender-affirming routes (Fuller & Riggs, 2018; Veale et al., 2017). A comment from our participants echoed these previous findings.

The only other time I have considered it [suicide] was during the process of realising I was trans, because it took me a long time to come to terms with it and I was scared of what I might have to deal with, but that improved with time and with support from friends and family. (Asian, Trans man, Youth)

Pathways of gender affirmation are not necessarily limited to medical interventions, but also include processes that are social (e.g. changing presentation through clothing) and legal (e.g. name change on formal documents; Oliphant et al., 2018; Olson et al., 2016). Some participants mentioned that coming to terms with their transgender identity improved their mental health: for example, one participant noted 'Forty years of depression cleared in two days after realising (or admitting to myself) that I am transgender. I had secretly cross dressed all my life since about 3–4 years old. I couldn't connect the depression with being transgender' (NZ European/Pākehā, Trans woman, Older adult). Others noted the mental health benefits of embracing their transgender identity through gender affirmation: for example, 'Coming out and transitioning has allowed me to get in touch with my body and emotions and achieve a more holistic wellbeing' (NZ European/Pākehā, Trans woman, Adult). Our findings supported a previous qualitative study with transgender youth that suggested being able to come out or self-define one's gender identity was an integral factor for transgender people in promoting personal resilience to mitigate the effects of gender minority stress (Singh et al., 2014).

Strengths and limitations

The Counting Ourselves study is the largest survey of transgender people in Aotearoa/New Zealand to date with recruitment of a diverse range of subgroups (gender identity, age, and ethnicity) across various geographical locations in this country. The majority of participants responded to the survey online and while a recruitment strategy was employed to reach wider audiences via internet groups and transgender community organisations, our sample may over-represent those who were younger and more connected to transgender communities. When identifying if there is a risk of bias in the open-text responses used for this specific paper (when compared to the overall sample for Counting Ourselves), we only found the proportion of people who responded to the open-text responses to differ by age group, with younger participants being less likely to leave a qualitative comment and older participants (aged 55 and above) being more likely to respond (see Table S1). Higher response rate among older

participants aligns with another study that analysed free-text comments embedded within large quantitative surveys (Cunningham & Wells, 2017). There were no statistically significant differences for other demographic characteristics (i.e. gender, ethnicity, and region), suggesting that there was minimal bias among participants who self-selected to provide a qualitative comment based on these other demographic factors.

Studies have shown that the use of 'any other comments' question in surveys could help to redress research power imbalances because participants can express their opinions or concerns without the constraints inherent in closed questions (O'Cathain & Thomas, 2004). Researchers' interpretation may be restricted, however, because respondents may provide only a few words or sentences, resulting in a lack of context and conceptual richness (O'Cathain & Thomas, 2004). However, in our study many participants provided often lengthy details about their perceptions of their mental health. We judged the open-ended comments in the mental health section to be very useful, given high numbers of participants (222) responded, providing valuable information to complement the quantitative findings published elsewhere (Tan et al., 2020b; Veale et al., 2019).

A strength of this paper is its ability in capturing the broad range of issues related to mental health such as gender minority stress and mental healthcare access. However, the space constraint does not allow us to go more in-depth on each inductive theme. There are many other open-ended comments that can be assessed from other sections of the survey to further consolidate our findings, but this is beyond the scope of this paper.

Conclusion and implications

This paper extends beyond the pathological perspective that positions transgender identity as the primary cause of internal distress among transgender people. Using indicators from health equity frameworks (e.g. Fredriksen-Goldsen et al., 2014), our findings affirm the need to understand the social determinants that result in mental health inequities among transgender people. Participants in our study reported individual and collective experiences of cisgenderism across a range of social settings. These included gender minority stress experiences (e.g. discrimination and misgendering), social exclusion, and loss of social support from friends and family members. The high rates of gender minority stress and violence among our participants endorse the recent Human Rights Commission's call to explicitly mention transgender people as a population whose human rights need to be safeguarded under the Human Rights Act 1993 in Aotearoa/New Zealand (New Zealand Human Rights Commission, 2020).

Transgender people have greater healthcare needs due to gender minority stress experiences and their need for gender-affirming medical interventions, and yet our findings suggest that they experience inequities and gaps in accessing both gender-affirming and mental health services. It is very concerning that healthcare services, which should be supporting transgender people during some of the most difficult times of their lives, may present obstacles to accessing medically necessary healthcare, may exacerbate mental health symptoms through gender minority stress and pathologisation models, or may be avoided for fear of unhelpful and non-inclusive treatments.

The lack of transgender-specific training among mental health professionals in Aotearoa/New Zealand is likely to contribute to the gaps in, trans clinical and cultural competency in healthcare provision for transgender people (Taylor et al., 2018). Being knowledgeable about the latest guideline for gender-affirming healthcare is crucial as the guideline situates transgender people at the core of decision-making processes and recognises their right to bodily autonomy and self-determination (American Psychological Association, 2015; Oliphant et al., 2018; Schulz, 2018). Health professionals should consider the informed consent model as an alternative to the Diagnostic Statistical Manual (DSM), as the former acknowledges transgender people as the experts of their own lives and that mental health assessment is an *option* rather than a *prerequisite* for access to gender-affirming interventions. Instead of relying on a diagnosis to gatekeep transgender people's access to gender-affirming care, health professionals can work alongside transgender patients by presenting them with information about the risks and benefits of undertaking gender- affirming medical interventions and ensuring that they are informed in authorising their own treatment. Our findings echo a recent submission to the government's mental health and addictions inquiry for the need to implement the informed consent model in healthcare settings, as well as, to urge policymakers to identify transgender people as a named priority in mental health policies (Clunie, 2018). When transgender people are feeling socially included in healthcare settings and are living in social environments that are supportive of their identities, our findings propose that they can achieve mental health equity and are able to participate fully in society.

Disclosure statement

The authors declared no potential conflict of interest.

Funding

This study was supported by a research grant from the Health Research Council of New Zealand (J.F.V., 17/587); the Rule Foundation; and the University of Waikato. The first author would like to acknowledge the financial support received through a University of Waikato Doctoral Scholarship.

Notes on contributors

Kyle Tan K.H. is a PhD student in psychology at Te Whare Wānanga o Waikato/The University of Waikato. He completed his Bachelor of Science with Honours in community psychology at University of Waikato in 2016, and has since developed a research interest in the mental health and wellbeing of LGBTIQ communities. His doctoral research

examines minority stress, protective factors, and mental health inequities of transgender people in Aotearoa/New Zealand.

Johanna M Schmidt is a senior lecturer in the School of Social Sciences at the Te Whare Wānanga o Waikato/University of Waikato, where she teaches sociology and social policy. Her research interests consistently revolve around gender and sexuality, with a significant focus on non-heteronormative identities. Her monograph, Migrating Genders: Westernisation, Migration, and Samoan Fa'afafine, published by Ashgate in 2010, is an examination of the impacts of westernisation and globalisation on the identities of fa'afāfine – transgender Samoans.

Sonja J Ellis is an associate professor in human development at Te Whare Wānanga o Waikato/The University of Waikato. She is an established researcher and scholar in the field of LGBTIQ Psychology, and is co-author of the textbook Lesbian, Gay, Bisexual, Trans, Intersex, and Queer Psychology: An Introduction (Cambridge University Press, 2020). She is currently undertaking research in relation to the inclusion of sexual and gender diversity in sexuality education; and around youth sexual health.

Jaimie F Veale is a senior lecturer in psychology at Te Whare Wānanga o Waikato/the University of Waikato. Her research interests include health inequities and social determinants of health for transgender people. Jaimie is a Pākehā (White), trans woman. Jaimie completed her PhD in psychology at Massey University in 2012. She worked for 3 years as a Postdoctoral Fellow at the University of British Columbia in Vancouver, Canada, researching the health of Canadian transgender young people. Jaimie is the Principal Investigator of Counting Ourselves: The Aotearoa New Zealand, Trans and Non-binary Health Survey. Jaimie is the founding President of the Professional Association for Transgender Health Aotearoa (PATHA), on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and an Associate Editor of the journals, Transgender Health and International Journal of Transgender Health.

Jack L Byrne is senior researcher and policy analyst working in the field of transgender health and human rights. From 2005-2014 he worked at the New Zealand Human Rights Commission where he project managed its Transgender Inquiry. Jack has worked on national, regional and international, trans research and advocacy projects. These have included co-authoring both the Asia Pacific, Trans Health Blueprint, and a manual for national human rights institutions in Asia and the Pacific on how they can advocate for the rights of LGBTQI/SOGIESC communities. Jack is the Chair of the Policy and Advocacy Committee for the Professional Association for Transgender Health Aotearoa (PATHA) and on the Advisory Board for the Asia Pacific Transgender Network.

References

Alpert, A. B., CichoskiKelly, E. M., & Fox, A. D. (2017). What lesbian, gay, bisexual, transgender, queer, and intersex patients say doctors should know and do: A qualitative study. *Journal of Homosexuality*, *64*(10), 1368–1389. https://doi.org/10.1080/00918369.2017.1321376

American Psychiatric Association. (1952) . *Diagnostic and statistical manual of mental disorders*. American Psychiatric Publishing.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

American Psychiatric Publishing.American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*(9), 832–864. https://doi.org/10.1037/a0039906

Ansara, Y. G. (2010). Beyond cisgenderism: Counselling people with non-assigned gender identities. In L. Moon (Ed.), *Counselling ideologies: Queer challenges to heteronormativity* (pp. 167–200). Ashgate.

Brennan, S. L., Irwin, J., Drincic, A., Amoura, N. J., Randall, A., & Smith-Sallans, M. (2017). Relationship among gender-related stress, resilience factors, and mental health in a Midwestern U.S. transgender and gender-nonconforming population. *International Journal of Transgenderism*, *18*(4), 433–445. https://doi.org/10. 1080/15532739.2017.1365034

Castro-Peraza, M. E., García-Acosta, J. M., Delgado, N., Perdomo-Hernández, A. M., Sosa-Alvarez, M. I., Llabrés-Solé, R., & Lorenzo-Rocha, N. D. (2019). Gender identity: The human right of depathologization. *International Journal of Environmental Research and Public Health*, *16*(6), 978. https://doi.org/10.3390/ijerph16060978

Chen, R., Zhu, X., Wright, L., Drescher, J., Gao, Y., Wu, L., Ying, X., Qi, J., Chen, C., Xi, Y., Ji, L., Zhao, H., Ou, J., & Broome, M. R. (2019). Suicidal ideation and attempted suicide amongst Chinese transgender persons: National population study. *Journal of Affective Disorders*, *245*, 1126–1134. https://doi.org/10.1016/j.jad.2018.12.011

Clarke, V., Braun, V., & Hayfield, N. (2015). Thematic analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 222–248). Sage.

Clunie, M. (2018). *Rainbow communities, mental health and addiction: A submission to the government inquiry into mental health and addiction – Oranga Tāngata, Oranga Whānau*. https://www.mentalhealth.org.nz/assets/Our-Work/policy-advocacy/Rainbow-communities-and-mental-health-submission-to-the-Inquiry-into-Mental-Health-and-Addiction-08062018.pdf

Cruickshank, J. (2012). Positioning positivism, critical realism and social constructionism in the health sciences: A philosophical orientation. *Nursing Inquiry*, *19*(1), 71–82. https://doi.org/10.1111/j.1440-1800.2011.00558.x

Cunningham, M., & Wells, M. (2017). Qualitative analysis of 6961 free-text comments from the first national cancer patient

experience survey in Scotland. *BMJ Open*, *7*(6), e015726. https://doi.org/10.1136/bmjopen-2016-015726

Danermark, B., Ekstrom, M., Jakobsen, L., Karlsson, J. C., & Bhaskar, P. R. (2002). *Explaining society: An introduction to critical realism in the social sciences*. Routledge.

Delahunt, J. W., Denison, H. J., Kennedy, J., Hilton, J., Young, H., Chaudhri, O. B., & Elston, M. S. (2016). Specialist services for management of individuals identifying as transgender in New Zealand. *New Zealand Medical Journal*, *129*(1434), 49–58. https://www.nzma.org.nz/journal-articles/specialist-services-for-management-of-individuals-identifying-as- transgender-in-new-zealand

Ellis, S. J., Bailey, L., & McNeil, J. (2015). Trans people's experiences of mental health and gender identity services: A UK study. *Journal of Gay & Lesbian Mental Health*, *19*(1), 4–20. https://doi.org/10.1080/19359705.2014.960990

Fredriksen-Goldsen, K. I., Simoni, J. M., Kim, H.-J., Lehavot, K., Walters, K. L., Yang, J., Hoy-Ellis, C. P., & Muraco, A. (2014). The health equity promotion model: Reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities. *American Journal of Orthopsychiatry*, *84*(6), 653–663. https://doi.org/10.1037/ort0000030

Fuller, K. A., & Riggs, D. W. (2018). Family support and discrimination and their relationship to psychological distress and resilience amongst transgender people. *International Journal of Transgenderism*, *19*(4), 379–388. https://doi.org/10. 1080/15532739.2018.1500966

Halliday, L. M., & Caltabiano, N. J. (2020). Transgender experience of mental healthcare in Australia. *Psychology*, *11*(1), 157–172. https://doi.org/10.4236/psych.2020.111011

Howell, T., & Allen, L. (2020). 'Good morning boys': Fa'afāfine and Fakaleiti experiences of cisgenderism at an all-boys secondary school. *Sex Education*, 1–15. Advance online publication. https://doi.org/10.1080/14681811.2020. 1813701

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. Transgender Survey*. National Center for Transgender Equality.Ministry of Health. (2020). *Delivering health services to transgender people*. https://www.health.govt.nz/our-work/pre ventative-health-wellness/delivering-health-services-transgender-people

New Zealand Human Rights Commission. (2020). *Prism: Human rights issues relating to sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) in Aotearoa New Zealand- A report with recommendations*. https:// www.hrc.co.nz/files/9215/9253/7296/HRC_PRISM_SOGIESC_ Report_June_2020_FINAL.pdf

New Zealand Psychologists Board. (2019). *Best practice guideline: Working with sex, sexuality, and gender diverse clients*. http://www.psychologistsboard.org.nz/cms_show_download. php?id=594

O'Cathain, A., & Thomas, K. J. (2004). "Any other comments?" Open questions on questionnaires – A bane or a bonus to research? *BMC Medical Research Methodology*, *4*(1), 25. https://doi.org/10.1186/1471-2288-4-25

Oliphant, J., Veale, J., Macdonald, J., Carroll, R., Johnson, R., Harte, M., Stephenson, C., & Bullock, J. (2018). *Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in Aotearoa New Zealand*. Transgender Health Research Lab, University of Waikato.

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, *137*(3), e20153223. https://doi.org/10.1542/peds.2015-3223

PATHA. (2019). *Is the provision of gender affirming health care equitable across the district health boards in Aotearoa, New Zealand?* https://patha.nz/News/8098808

Pitts, M. K., Couch, M., Hunter, M., Croy, S., & Mitchell, A. (2009). Transgender people in Australia and New Zealand: Health, well-being and access to health services. *Feminism & Psychology*, *19*(4), 475–495. https://doi.org/10.1177/ 0959353509342771

Schulz, S. L. (2018). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *Journal of Humanistic Psychology*, *58*(1), 72–92. https://doi.org/10.1177/0022167817745217

Singh, A. A., Meng, S. E., & Hansen, A. W. (2014). "I am my own gender": Resilience strategies of, trans youth. *Journal of Counseling & Development*, *92*(2), 208–218. https://doi.org/10.1002/j.1556-6676.2014.00150.x

Tan, K. K. H., Ellis, S. J., Schmidt, J. M., Byrne, J. L., & Veale, J. F. (2020b). Mental health inequities among transgender people in Aotearoa New Zealand: Findings from the Counting Ourselves survey. *International Journal of Environmental Research and Public Health*, *17*(8), 2862. https://doi.org/10.3390/ijerph17082862

Tan, K. K. H., Schmidt, J. M., Ellis, S. J., & Veale, J. F. (2019). Mental health of, trans and gender diverse people in Aotearoa/ New Zealand: A review of the social determinants of inequities. *New Zealand Journal of Psychology*, *48*(2), 64–72. https://www.psychology.org.nz/download_file/view/156/334/3 34

Tan, K. K. H., Treharne, G. J., Ellis, S. J., Schmidt, J. M., & Veale, J. F. (2020a). Gender minority stress: A critical review. *Journal of Homosexuality*, *67*(10), 1471–1489. https://doi.org/10.1080/00918369.2019.1591789

Taylor, O., Rapsey, C. M., & Treharne, G. J. (2018). Sexuality and gender identity teaching within preclinical medical training in New Zealand: Content, attitudes and barriers. *New Zealand Medical Journal*, *131*(1477), 35–44. https://

www.nzma.org.nz/journal-articles/sexuality-and-gender-identity-teaching-within-preclinical-medical-training-in- new-zealand-content-attitudes-and-barriers

Telfer, M. M., Tollit, M. A., Pace, C. C., & Pang, K. C. (2018). Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. *Medical Journal of Australia*, *209*(3), 132–136. https://doi.org/10.5694/mja17.01044

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity*, *2*(1), 65–77. https://doi.org/10.1037/ sgd0000081

Tomita, K. K., Testa, R. J., & Balsam, K. F. (2019). Gender-affirming medical interventions and mental health in transgender adults. *Psychology of Sexual Orientation and Gender Diversity*, *6*(2), 182–193. https://doi.org/10.1037/sgd0000316

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, *77*(1), 68–76. https://doi.org/10.1001/jamapsychiatry.2019.2285

Veale, J. F., Byrne, J., Tan, K. K. H., Guy, S., Yee, A., Nopera, T., & Bentham, R. (2019). *Counting ourselves: The health and wellbeing of, trans and non-binary people in Aotearoa New Zealand*. Transgender Health Research Lab, University of Waikato.

Veale, J. F., Peter, T., Travers, R., & Saewyc, E. M. (2017). Enacted stigma, mental health, and protective factors among transgender youth in Canada. *Transgender Health*, *2*(1), 207–216. https://doi.org/10.1089/trgh.2017.0031

World Health Organization. (1975). *International classification of diseases and related health problems. 9th revision*.World Health Organization. (n.d.). *WHO/Europe brief—Transgender health in the context of ICD-11*. http://www.euro.who. int/en/health-topics/health-determinants/gender/gender-definitions/whoeurope-brief-transgender-health-in-the-context-of-icd-11

Supplemental online material.

Table S1.
Demographic details of participants who provided a response in the open-text box

	Respond n (%)	**Adj Std Residuals**
Age Groups		
14-24	80 (20.1)	-2.7
25-34	65 (24.8)	0.1
35-44	32 (31.4)	1.7
45-54	14 (20.0)	-0.9
55-100	31 (41.9)	3.6
	$\chi 2$ (4) = 19.648, p = .001	
Gender		
Trans women	71 (26.3)	0.8
Trans men	55 (21.3)	-1.4
Non-binary AFAB	78 (26.6)	1.0
Non-binary AMAB	18 (21.4)	-0.7
	$\chi 2$ (3) = 3.021, p = .388	
Ethnicity		
Māori	27 (23.7)	-0.2
Pākehā/NZ European	180 (25.2)	1.0
Others[a]	15 (19.0)	-1.2
	$\chi 2$ (2) = 1.553, p = .460	
Regions		
Auckland	60 (22.1)	-1.2
Wellington	67 (26.2)	0.7
Other north island	41 (26.3)	0.5
Other south island	52 (25.0)	0.1
	$\chi 2$ (3) = 1.539, p = .673	

[a]Due to the low number of respondents for Pasifika, Asian, and others, responses of these ethnic groups were merged.